

Receipt # _____

**TROY RECREATION DEPARTMENT'S
2005
BASEBALL CLINIC
AGES 8-17**

Name _____ Male/Female _____

Address _____ Phone _____

(street)

Zip _____

(city)

E-Mail Address _____

Name of School _____ Grade _____

Birthdate _____

Age _____

Allergic to any medication? _____

Doctor's Name _____ Phone _____

Emergency call _____ Phone _____

(neighbor or relative)

PLEASE CHECK CLASS

_____ Session I

June 6-9, Mon.-Thurs.

June 13-16, Mon.- Thurs.

_____ Session II

June 20, Mon.

June 27-30, Mon.-Thurs.

July 5-8, Tues.-Fri. (July 8 will be for 8-10 yr. olds)

9:00-10:00 am, Tuesday & Thursday

9:00-10:00 am, Monday & Wednesday

10:00-11:30am, Monday thru Thursday (Daily)

_____ Ages 8-10- \$15.00

_____ Ages 11-13 - \$18.00

_____ Ages 14-17 - \$22.00

WAIVER AND RELEASE

We, the undersigned being fully aware of the dangers inherent to the sport of baseball, do give permission for our son/daughter to participate in the baseball clinic. We do hereby expressly waive any and all claims and rights of whatever nature, which may arise against the City of Troy, Troy Recreation Department, Troy Recreation Director, clinic instructor, the supervisory staff, or their agents or servants, as a result of injuries incurred by our child while participating in this program.

Date _____ Signature _____
(parent or legal guardian)

REFUND POLICY: Department will make program refunds only for the following:

1. If the program is cancelled by the department.
2. If the registered participant moves out of town before the program starts.
3. If the registered participant becomes ill before the program starts and furnishes a Doctor's statement.